Format for ANSWERING REVIEWERS

May 2nd, 2015

Dear Editor,

Please find enclosed the edited manuscript in Word format (file name: Body text reviced1).

Title: Endoscopic snare papillectomy for a solitary Peutz–Jeghers type polyp in the duodenum with ingrowth into the common bile duct: case report

Author: Keiichi Suzuki, Hajime Higuchi, Sayaka Shimizu, Masaru Nakano, Hiroshi Serizawa, Shojiro Morinaga

Name of Journal: *World Journal of Gastroenterology*

ESPS Manuscript NO: 17012

The manuscript has been improved according to the suggestions of reviewers:

1 Format has been updated
We also added COMMENTS.

2 Revision has been made according to the suggestions of the reviewer

THE LISTS OF CHANGES TO RESPOND TO THE COMMENTS

(1) How the authors made a decision of the therapeutic strategy and specifically on the question of endoscopic vs. surgical resection? There are no definitive guidelines as to the size or diameter of above which endoscopic removal of hamartomatous polyps should be attempted and this is one of the few reports of successful endoscopic resection of a polyp of this size, especially considering the added feature of it's ingrowth into the CBD. Is size and intraductal extension or morphological features indicating cancerous predesposition a criterion for surgical referral?

- Reply -

Thank you for the relevant suggestions. As you pointed out, there is no definitive guideline for treatment of Solitary duodenal PJ type hamartomatous polyps. Like as other common gastroduodenal polyp, solitary PJ type polyp with features of size, sessile type, or with suspicion of submucosal invasion, should be considered for surgical resection. From table1 we presented in the manuscript, patients with larger polyps (>50 mm) required surgery. On the other hand, the maximum diameter may be non-indicative of malignancy, as some patient had a small malignant polyp only 10 mm in diameter. Therefore the differential diagnosis by morphological features is difficult. Endoscopic biopsies must be done to make a decision of treatment strategy. When finding form biopsy was malignant, surgery should be done according to the depth of tumor invasion. Endoscopic ultrasonography is useful.

We added this sentence to DISCUSSION. Highlighted with yellow.

(2) The authors' opinion on pancreatic and biliary stenting during endoscopic treatment especially when the major duodenal papilla is involved.

- Reply -

Endoscopists usually try to insert tube stents into both of CBD and MPD after endoscopic snare papillectomy (ESP) to avoid acute pancreatitis, and stenosis of CBD and MPD outlets.

(3) How the authors determined whether a polyp rather than a cancer and what would have been done in this case?

- Reply -

Of course, possibility of malignant transformation must be considered always. When pathological findings from biopsies showed no evidence of malignancy, however, it is reasonable to choose endoscopic resection. We decided to undergo ESP rather than surgery, because pathological findings from pre-ESP biopsies revealed no malignancy. When the final pathological diagnosis showed malignant transformation, surgical resection should be considered according to tumor invasiveness. Meanwhile, comprehensive and cautious decision of surgical indication is required by consideration of patient characteristics, such as age, past histories, and general conditions. In our case, surgery might not be done even though the polyp involved malignant part due to his high-age and general conditions.

3 References and typesetting were corrected

Thank you again for publishing our manuscript in the *World Journal of Gastroenterology.*

Sincerely yours,

Keiichi Suzuki, M.D., Ph.D.
Address: Department of Surgery, Kitasato Institute Hospital, 5-9-1, Shirogane, Minato-ku, Tokyo 108-8642, Japan.
E-Mail: k1suzuki@me.com
Phone: +81-3-3444-6161
FAX: +81-3-3448-0553